STATE OF WASHINGTON DEPARTMENT OF LABOR AND INDUSTRIES

PO Box 44261 Olympia, Washington 98504-4261

BILLING INSTRUCTIONS – STATE FUND CLAIMS STATEMENT FOR MISCELLANEOUS SERVICES BILL FORM

F245-072-000

Advanced Registered Nurse Practitioner,
Certified Registered Nurse Practitioner, Registered Nurse,
Dental Services, Durable Medical Equipment,
Drug & Alcohol Treatment, Licensed Massage Therapy,
Nurse Case Management, Obesity Treatment,
Occupational Therapy, Optometry/Optician Services,
Vocational Rehabilitation Services

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BILLING INSTRUCTIONS

Labor and Industries (L&I) processes all provider bills using an automated system called the Medical Information Payment System (MIPS). In order to process your bills promptly and accurately, they must be completed as described in these instructions. Improperly submitted bills will be denied or returned for completion or correction.

For billing requirements for Self-Insurers and their service companies contact the Self-Insurance section at 360-902-6901.

L&I Provider Account Number Required:

If you do not have an L&I provider account number, please call Provider Accounts at (360) 902-5140 to request a provider application form. This form and several other of the most frequently requested forms can also be downloaded from our website at www.wa.gov/lni/forms. You may also request additional forms from your local field service location; a listing of these locations is contained on the last page of this billing instruction booklet. Submit your bill after you receive your L&I provider account number or for your first submission only, attach it to your completed application.

Billing on Paper Forms:

Submit charges on the Department's "Statement for Miscellaneous Services" bill form (F245-072-000).

Mail "Statement for Miscellaneous Services" bill forms to:

Department of Labor and Industries PO Box 44267 Olympia, Washington 98504-4267

Bill Forms – Where and How to get them:

Bills must be submitted on ORIGINAL (not photocopied) Statement for Miscellaneous Services bill forms. Bill forms are furnished free of charge to providers. To order forms, contact the Labor and Industries Field Service Location office nearest you; a listing of these locations is contained on the last page of this billing instruction booklet. Providers outside Washington State may contact Provider Accounts at (360) 902-5140 or the Provider Hotline at 1-800-848-0811. When ordering, give your full name, address, L&I provider account number, quantity needed for six months, and the L&I form number (FXXX-XXX-000 for single sheet, or FXXX-XXX-111 for continuous pinfeed).

Billing Electronically:

Please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 if you are able to and are interested in submitting bills electronically.

When to Submit Bills:

You should submit bills at the time the first required report is written. Billings should then be sent every 30 days thereafter until the conclusion of services. A separate bill form must be completed for each claim number but each bill form may contain more than one date of service. All dates of service must be billed separately.

When payments are made:

The department issues warrants to providers every two-weeks for bills that have processed to final status. An L&I Remittance Advice is also provided to you at two-week intervals. Remittance Advices provide a report of the status of your bill(s) that have been processed, or are in process. When contacting the department with a billing problem, please have the appropriate copy of the Remittance Advice in hand before calling. Many billing questions can be answered by reading the Remittance Advice.

Credit Balance Bills (CRE) – The bills will be held in abeyance until the credit balance is satisfied. These bills should be treated as "Bills in Process". Do not post or rebill these bills as long as they appear in this section. **This is money owed to the department.** Payment(s) to clear your credit balance should be mailed to:

Department of Labor and Industries Cashier's Office PO Box 44835 Olympia WA 98504-4835

Limits on Bill Processing:

Bills must be received within one year of the date of service to be considered for payment. Rebills must be submitted for services denied if a claim was closed and subsequently reopened or if a claim or diagnosis was rejected and subsequently allowed. In these instances, the rebill must be received within one year of the date the final order is issued, which subsequently reopens or allows the claim or diagnosis.

For Help:

If you have questions about "PAID BILLS", "DENIED BILLS" or "ADJUSTMENT BILLS", please call the Provider Hotline at 1-800-848-0811. **Please have a copy of the appropriate Remittance Advice in hand before calling.**

If you have questions about "BILLS IN PROCESS", please call the automated Claim Information line at 1-800-831-5227, for up to the minute bill status. From that line, you may choose the "zero" option to be connected to the Bill Payment Unit.

If you have general questions about an injured workers claim or time-loss payment, please call the automated Claims Information line at 1-800-831-5227. More than one claim number can be accessed per phone call and any 'wait time' is minimal.

If an injured worker has general questions about their claim, please give them the 1-800-831-5227 number or the 1-800-LISTENS (547-8367) number for assistance with claim problems including time-loss. If they have bill questions, you may give them the Provider Hotline number 1-800-848-0811.

Note: A completed Report of Accident does not constitute a bill. Bills must be submitted separately to be considered for payment.

ARNP, CRNA, RN Dental

PROVIDER SPECIFIC INSTRUCTIONS

Advanced Registered Nurse Practitioner Certified Registered Nurse Practitioner Registered Nurse

Type of Service:

Use Type of Service code "N"

Advanced Registered Nurse Practitioner

Licensed nursing rules and billing instructions are contained in WACs 296-23-240 and -245. ARNP services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician.

Certified Registered Nurse Anesthetists

Licensed nursing rules and billing instructions are contained in WACs 296-23-240 and -245. CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are -QX and -QZ.

Please also refer to the "Anesthesia Payment Policies" section of the current fee schedule.

Registered Nurse as Surgical Assistants

Licensed registered nurses may perform surgical assistant services if the registered nurse submits all of the following documents to the department or Self-Insurer:

- A photocopy of her or his valid and current registered nurse license, and
- A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is **ninety** percent (90%) of the allowed fee that would otherwise be paid to an assistant surgeon (physician).

For further information please refer to WAC 296-23-240 & WAC 296-23-245

Dental Services

Type of Service:

Use Type of Service code "4" if billing Level II HCPCS code(s). These codes begin with the letter "D", followed by 4 numbers (e.g., D0120). See the HCPCS section in the current fee schedule for a listing of codes.

Use Type of Service code "3" if billing Level I CPT code(s). These codes consist of 5 numbers (e.g., 99201). See the Medicine section in the current fee schedule for a listing of codes.

DME
Drug & Alcohol

Copies of the HCPCS Level I and II codes may be purchased from:

The Superintendent of Documents United States Government Printing Office Washington DC 20402

DME & Other Services

(Includes Hearing Aid Fitter/Dispensers, Audiologists, Interpreters, Ambulance, Public Transportation)

Type of Service:

Use Type of Service code "9" on the Statement for Miscellaneous Services form when billing for durable medical equipment or any of the above services listed.

Modifier Codes:

Use modifier code "RR" for rental items.
Use modifier code "RP" for replacement and repair.

Pharmacies and durable medical equipment providers may bill for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax, and fitting fees are not payable separately. DME suppliers should include these charges in the total charge for the supply. For taxable items, an itemized invoice may be attached to the bill, but is not required.

DME suppliers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account number. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

TENS units (Transcutaneous Electrical Nerve Stimulators) and supplies are paid under special contract only. Refer to the section on "Transcutaneous Electrical Nerve Stimulators (TENS)" in the current fee schedule under "Specialty and Administrative Services" section.

For further information on miscellaneous services and appliances, refer to WAC 296-23-165.

Drug & Alcohol Treatment

Type of Service:

Use Type of Service code "9" and the Local codes listed later in this section when billing for drug and alcohol rehabilitation services.

Use Type of Service code "3" and standard CPT codes when billing for laboratory procedures.

WAC 296-23-185 Drug and alcohol rehabilitation services. Authorization requirements for these services may be found in WAC 296-20-03001 and 296-20-055. Please refer to the provider bulletin listing in the current fee schedule for any information updates. If you would like to obtain a copy of the most current provider bulletin, please call the Health Service Analysis section at (360) 902-6799.

Drug & Alcohol LMT

0141M	Intake Evaluation
0142M	Physical Examination
0143M	Individual Therapy, Routine Visit
0144M	Individual Therapy, Brief Visit
0145M	Group Therapy
0146M	Chemotherapy
0147M	Medication Adjustment
0149M	Detoxification facility (room & board)

Licensed Massage Therapy

Type of Service:

Use Type of Service code "9" and procedure code 97124 when billing for Massage Therapy Services.

Note: DO NOT bill services spanning multiple dates. Bill one date per line.

Massage therapists are allowed to bill only one CPT code for massage (97124). 97124 is a timed code with a 15 minute value. Massage therapists should bill their usual and customary fee and designate the duration of the massage therapy treatment by the number of units in the 'UNIT' field.

Units are measured as follows: 1 unit = 15 minutes

2 units = 30 minutes 3 units = 45 minutes 4 units = 1 hour

The department will not reimburse massage therapists for additional costs that are not specifically allowed. Application of hot and cold packs, anti-friction devices and lubricants (e.g., oils, lotions, emollients, etc.) are bundled, and are not payable separately.

"No inpatient massage therapy treatment will be allowed when such treatment constitutes the only or major treatment received by the worker. See WAC 296-20-030 for further information."

Refer to WAC 296-23 for additional information.

Authorization Required:

"Massage therapy treatment will be permitted when given by a licensed massage practitioner only upon written orders from the worker's attending doctor." (WAC 296-23-250)

"Massage therapy in the home and/or places other than the practitioners usual and customary business facilities will be allowed only upon prior justification and authorization by the department or self-insurer." (WAC 296-23-250)

"Massage therapy treatments exceeding once per day must be justified by attending doctor." (WAC 296-23-250)

Please refer to WAC 296-23-250 for additional information and reporting requirements.

Nurse Case Management

Type of Service:

Use Type of Service "9" with Local codes 1220M – 1225M when billing for Nurse Case Management Service.

All nurse case management services require prior authorization. Please refer to PB 98-01 for Payment Policy for Nurse Case Management Services. To request a copy of the current provider bulletin, please call (360) 902-6799 or can be viewed/downloaded from www.wa.gov/lni/hsa/hsa_pbs.htm.

Nurse case management services are capped at 50 hours of service including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases contingent upon review by the insurer.

CASE NOTE INSTRUCTIONS

A case record will be created and maintained on each claim. The case record shall present a chronological history of the injured worker's progress in Medical Case Management services. A case manager's services can be denied or reduced if the required documentation is not provided in the case notes or if the service does not match the procedure code billed.

Case notes shall be written when a service is given and shall specify:

- 1) When a service was provided,
- 2) What type of service was provided, using case note codes (See Attachment A),
- 3) A description of the service provided including person(s) involved, outcome, and future plan, if applicable and
- 4) How much time was used.

Copies of reports, correspondence, and expenses shall be maintained in the case record.

Case note codes will be used to document the type of services provided to or on behalf of the injured worker. Case note codes, including case note documentation requirements are explained fully in Attachment A. The table below describes the case note and billing codes. New maximum allowable fees are also noted.

CASE NOTE CODES	BILLING CODES
PCW, PCD, PCE, PCV, PCP, and PCO	1220M – Phone Calls Per Unit
VW, VD, VE, VV, VP, and VO	1221M – Visits Per Unit
CR, FRV, COR, RE, RW, RR, and TC	1222M – Case Planning Per Unit
TR, WA	1223M – Travel/Wait Per Unit
N/A	1224M – Mileage per mile
N/A	1225M – Expenses at Cost (includes
	parking, ferry, cab, toll fees, lodging and
	airfare)

^{* - 1} unit equals 6 minutes of time. Per unit amounts are multiplied by 10 to equal the rate per hour.

Case note codes shall be converted to billing codes as bills are processed by the nurse case manager or firm. For example, all time associated with telephone calls during a 30-day period is added, converted

to units of service and then total charges. Likewise, all time associated with visits during a 30-day period is added, converted to units of service and then total charges, etc. Examples below describe how to convert time to units and calculate total charges. Examples are also shown for mileage and expenses.

Phone Calls, Visits or Case Planning:

Step 1 – Time to Units

Total minutes divided by 6 = Total No. of Units 102 minutes/6 = 17 units

Step 2 – Units of Total Charges

Total units time per unit charge = Total charges 17 units x \$8.09 = \$137.53

Travel / Wait:

Step 1 – Time to Units

Total minutes divided by 6 = Total No. of Units 150 minutes/6 = 25 units

Step 2 – Units to Total Charges

Total units times per unit charge = Total charges 25 units x \$3.98 = \$99.50

Mileage:

Mileage is reimbursed at the Washington State rate for mileage reimbursement. The current amount is \$.35 per mile. Mileage during a 30-day period is added then multiplied by .35 to obtain the total mileage expenses for the month. For example:

112 miles x .35 = \$39.20

Expenses:

Expenses will be reimbursed at cost. Receipts for expenses shall be maintained in the case record. Receipts for parking are not required, but preferred. All expenses with a 30-day period shall be added, then coded as 1225M on the Statement for Miscellaneous Services bill form. Attachment B describes covered and non-covered medical case management expenses.

An example follows:

5.00 (parking) + 7.50 (records) = 12.50

ATTACHMENT A CASE NOTE CODES

Phone Calls

PCW: Injured worker, family members, injured workers' attorney or legal

representative.

PCD: Department of Labor and Industries staff.
PCE: Employer or employer representatives.
PCV: Vocational rehabilitation counselors.

PCP: Attending physician, physician consultants, and other allied healthcare

personnel.

PCO: Governmental agencies, social services, community and/or volunteer resources,

etc.

Visits

VW: Injured worker, family members, injured workers' attorney or legal

representative.

VD: Department of Labor and Industries staff.

VE: Employer or employer representative

VP: Attending physician, physician consultants, and other allied healthcare

personnel.

VO: Governmental agencies, social services, community and/or volunteer resources,

etc.

Case Planning

CR: Case Review: review and analyze current or new data between monthly

reporting periods.

FRV: File Record Review: review and analyze historical file documentation.

COR: Correspondence: prepare correspondence, i.e., letters memo, fax.

RE: Research: research medical literature, condition specific.

RW: Report Writing: prepare monthly reports, i.e., initial, progress and closure

reports and special reports.

RR: Record Retrieval: obtain medical records, reports or evaluations.

TC: Team Conference: participate in or conduct team conferences.

Travel / Wait

TR: Travel: travel to person being visited

WA: Wait to meet with person(s) being visited.

Mileage **Not applicable**.

Expenses **Not applicable**.

CASE NOTE CODES. DESCRIPTIONS AND INSTRUCTIONS

PHONE CALLS

<u>Definition:</u> made by or to a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instructions; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to facilitate the worker's recovery; to assess the success of current therapies or treatment, overall.

<u>Billing Instructions:</u> Bill 1 unit of service for each 6 minutes of time. Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the call, to whom the phone call was made, their title if applicable (MD, RN, DO, PT, etc.), the reason for the call, details of the discussion and length of phone call.

Billing coded and Descriptions:

PCW: Includes phone calls to injured worker, family members, injured

worker's attorney or legal representatives.

PCD: Includes phone calls to Department of Labor and Industries claims

managers, occupational nursing consultants, supervisors, and other

department staff.

PCE: Includes phone calls to employer or employer representatives to access

information or facilitate return to work for the injured worker.

PCV: Includes phone calls to vocational rehabilitation counselors for

coordination of rehabilitation services.

PCP: Includes calls to attending physician, physician consultants, and other

allied health care personnel to facilitate health care service delivery.

PCO: Includes phone calls to other governmental agencies, social services,

community and/or volunteer resources to provide for the injured

worker's health care needs.

VISITS

<u>Definition</u>: Onsite meetings or scheduled face-to-face meetings by a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instruction; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to further recovery; to assess the success of current therapies or treatment overall when telephonic services are not adequate to obtain the necessary information.

Billing Instructions: Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the visit, who was visited, their title if applicable (MD, RN, DO, PT, etc.), the reason for the visit, details discussed and the length of visit.

Billing Codes and Descriptions:

VW: Includes visits with injured worker, family members, injured workers'

attorney or legal representative.

VD: Includes visits with the Department of Labor and Industries claims

managers, occupational nursing consultants, supervisors, and other

department staff.

VE: Includes visits to employer or employer representatives to access

information or facilitate return to work for the injured worker.

VV: Includes visits with vocational rehabilitation counselors for

coordination of rehabilitation services.

VP: Visits with the attending physician consultants, and other allied health

care personnel to facilitate health care service delivery.

VO: Visits with other governmental agencies, social services, community

and/or volunteer resources to provide for the injured worker's health

care needs.

CASE PLANNING

1) Case Review (CR)

<u>Definition / Billing Instructions:</u> The time taken to review and analyze current or new data between monthly reporting periods; includes documentation of impact of new data on overall case plan. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include the date, case note with the data and description of the data, analysis, and plan. Case planning is not to be billed for writing case notes to document onsite visits or phone calls. Phone calls and visits already include payment for associated documentation.

2) File Record Review (FRV)

<u>Definition / Billing Instructions:</u> The time taken to review and analyze historical file documentation at the onset of referral to medical case management. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include a case note describing the date of review, material reviewed, and time spent reviewing the records. If a separate file review is completed, a copy of the document will be kept in the working file and attached to the monthly report. Copies of historical file documents shall be kept with the nurse case manager's case record.

3) Correspondence (COR)

<u>Definition / Billing Instructions:</u> The time taken to prepare correspondence, i.e., letters, memo, fax to the department, injured worker, provider, vocational counselor and other governmental agencies, social services, community and/or volunteer resources for the purpose of updating,

clarifying or confirming the medical treatment plan. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include the date when the correspondence was produced, a case note describing the correspondence and time to prepare the correspondence. A copy of the document will be kept in the case record and attached to the monthly report.

4) Research (RE)

<u>Definition / Billing Instructions:</u> The time taken to research medical literature, condition specific. Bill 1 unit of service for each 6 minutes of time.

Documentation of this service is to include the date research was conducted, a summary of the findings of the literature review, the impact of the information on the injured worker's case plan, and time to complete research. If document produced, a copy will be kept in the case record and attach to the monthly report.

5) Report Writing (RW)

<u>Definition / Billing Instructions:</u> The time taken to prepare monthly reports, i.e., initial, progress and closure reports, as well as special reports requested by department representatives. Bill 1 unit of service for each 6 minutes of time. The initial report shall not exceed 2 billable hours per case. Progress and closure reports shall not exceed 1 hour per case.

Documentation of this service is to include the date of the report, a notation in the case notes, a report, (for special reports, note requesting part in case note documentation using appropriate billing code, e.g., PCD or VD) and the time to complete the report. A copy of the report will be kept in the case record and sent to the claims representative on a monthly basis.

6) Record Retrieval (RR)

<u>Definition / Billing Instructions:</u> The time taken to obtain records, reports or evaluations not currently contained in the department's records for case planning. This method of obtaining records should be limited. The most cost-effective method of obtaining records should be used first, prior to use of professional time, e.g., faxing, mailing, etc. Bill 1 unit of service for each 6 minutes of time.

Documentation of this service is to include the date of record retrieval, a case note identifying the record source, summary of records obtained, and the total time (including travel, wait, and photocopying cost) to obtain the report.

7) Team Conference (TC)

<u>Definition / Billing Instructions:</u> The time taken to participate in or conduct a team conference with 3 or more health care professionals, vocational rehabilitation counselors, employer, injured worker and/or representative, or other governmental agencies, social services, community and/or volunteer resources to coordinate activities of patient care, provide for the injured worker's health care needs and/or return to work efforts for the injured worker. Includes documentation of

impact of conference data on the overall case plan. Bill 1 unit of service for each 6 minutes of time. Visit codes are not to be billed for team conferences.

Documentation of this service is to include the date of the conference, a case note, summary of conference findings, analysis, plan of action, and time.

TRAVEL (TR)

<u>Definition / Billing Instructions:</u> The time to travel from the nurse case manager's home office or home, whichever is closest, to the person being visited. Bill 1 unit of service for each 6 minutes of time. Transportation costs including parking, ferry, toll fees, cab, and airfare are reimbursable at cost. Travel expenses resulting from single or multiple visits which involve visits or conferences on more than one injured worker must be prorated between the multiple injured workers visited. For example, if the case manager travels to a hospital in Seattle, and visits with 3 injured workers, the costs should be billed by dividing the mileage and travel time between the three cases.

Documentation of the service is to include date of travel, a case note with starting and ending location, whether visit was prorated, mileage, odometer reading start and finish, and other associated transportation expenses, and time.

Mileage costs may be reimbursed at \$.35 per mile or the current Washington state rate for mileage reimbursement. Mileage costs should be billed using the 1224M mileage billing code. Parking, toll, ferry, cab or airfare expenses will be billed with the new 1225M expense billing code. Meals and lodging required outside normal business hours will be paid with prior approval by the claims manager and at the state per diem rate in effect at the time for the area. Meals and lodging and a copy of any original invoice shall be kept in the case record for a minimum of five years.

WAIT (WA)

<u>Definition / Billing Instructions:</u> The time to wait to meet with person(s) being visited during scheduled visits. Bill 1 unit of service for each 6 minutes of time to a maximum of 2 hours. Case managers are encouraged to use wait time to conduct other business e.g., phone calls, visits, case planning, file record review, and record retrieval during wait time.

Documentation of the service is to include the date of wait time, a case note with location of visit, time of arrival at appointment, and end time (when appointment visit began).

ATTACHMENT B

COVERED AND NON-COVERED EXPENSES

COVERED EXPENSES:

The following expenses will be covered –

- Transportation other than mileage, including parking, ferry, toll fees, and cab. Mileage is reimbursed at \$.35 per mile or the current Washington state rate for mileage reimbursement.
- ❖ Meals and lodging required outside normal business hours with prior claims manager approval and at the Washington state per diem rate in effect at the time for the area.
- ❖ Airfare with prior approval from the claim manager.
- ❖ Mileage greater than 150 miles round trip requires prior approval from the claims manager.
- ❖ Fees for obtaining medical records, reports or evaluations per request of department and at no more than the maximum allowable rate of .35 per page.

NON-COVERED EXPENSES:

The following expenses will not be covered –

- Activities associated with nurse case manager training, e.g., training on office policies and procedures, including report writing and billing.
- Supervisory activity such as supervisor nurse case manager visits, case reviews or conferences between supervisor and nurse case manager.
- ❖ Postage, printing or photocopying costs (with the exception of medical records per request of department). See above explanation.
- * Telephone expenses including unanswered phone calls, long-distance phone calls, and facsimile.
- Time spent on any clerical activity, including processing a referral, file "set up", typing, copying, mailing, distributing, filing, invoice preparation, record keeping, delivering or picking up mail.
- Travel time to a post office or a fax machine.
- ❖ Wait time exceeding 2 hours.
- ❖ Fees related to legal work, e.g., deposition, testimony, etc. Legal fees may be charged to the requesting party, but not the claim. Contact the requesting party regarding how legal services are billed.
- ❖ Any other administrative cost not specifically mentioned above.

Obesity Occupational Thpy

Obesity Treatment

Type of Service:

Use Type of Service code "9" and the Local codes listed below.

While obesity does not meet the definition of an industrial injury or occupational disease, temporary treatment of obesity may be allowed in some cases. All obesity treatment services require prior authorization. Refer to Provider Bulletin 97-03 for more information.

The attending doctor may request a consultation with a certified dietician or nutritionist (RD) to determine if an obesity treatment program is appropriate for the injured worker.

The procedure codes for obesity treatment are as follows:

1030M Intake Dietary Evaluation1034M Dietary Reevaluation

Occupational Therapy

Type of Service:

Use Type of Service code "9" for HCPCS codes Use Type of Service code "3" for CPT codes

*** After 12 treatments, you must get new orders from the attending physician and authorization from the claims manager

REPORTING REQUIREMENTS

NOTE: CURRENTLY THERE ARE NO PROVISIONS TO PAY OCCUPATIONAL THERAPISTS SEPARATELY FOR REPORTS

*** DO NOT ATTACH REPORTS TO THE BILLS***

Send all reports (correspondence) for State Fund claims to:

Department of Labor & Industries PO Box 44291 Olympia WA 98504-4291

- A. Consultation reports
- B. Laboratory and X-ray reports
- C. Special reports and/or narratives to support level of office visit or procedure
- D. Operative reports/anesthesia records

- E. Periodic office notes
- F. Periodic chart notes

Occup. Thpy con't.
Optometry/Optician
Voc Rehab Svcs

The injured workers' name and claim number must be placed in the upper right corner of <u>each page</u> on any correspondence or report.

The cost invoices for supplies furnished are not routinely required, but may be requested by the department in specific cases.

See WAC 296-20 for additional requirements and report definitions.

Optometry/Optician Services

Type of Service:

Use Type of Service code "9" for HCPCS codes Use Type of Service code "3" for CPT codes

Please refer to WAC 296-20-100 Eye glasses and refractions for more information.

Vocational Rehabilitation Services

Type of Service:

Use Type of Service code "V" for Vocational codes

This section details the requirements and information Vocational Rehabilitation providers should know and follow in submitting bills.

How to Submit a Bill

Each provider who works on a referral must bill separately and must list the precise number of units of service worked for each date span on a referral. Each date span billed must have both a start and end date. The provider must also bill for each referral separately. Even if a third party does the billing, the provider receiving the referral is responsible for ensuring that all billing is correct.

In cases where more than one provider delivers services on a referral (e.g., where interns assist on referrals assigned to a VRC, or where one VRC covers for another VRC who is ill), each provider must bill separately for services delivered on the referral. Each provider must use his or her individual provider number, as well as the payee provider number and the referral Identification Number (see section below). The department will reject and not pay bills missing this information. It is important that providers understand that the payee provider identification number of <u>all other</u> providers working on a referral must be the same as the assigned Vocational Rehabilitation Counselor's, or the department will not pay the bill.

Example: Acme Rehabilitation employs counselor X, as well as interns Y and Z. Acme may not submit aggregate bills: Acme Rehabilitation must submit a separate bill for Counselor X, Intern Y, and Intern Z—for each referral worked by X, Y, and Z.

For more detailed information about completing billing forms, consult the samples of completed forms, which are located in an attached section.

Reimbursement Rates

The department has established separate reimbursement rates for different provider specialties. The department will reimburse interns at 85% of the VRC professional rate: forensic evaluators will receive 120% of the VRC professional rate.

The table below lists the professional, travel/wait, and mileage rates for vocational services:

Provider Type	Rate
VRC Professional Rate	\$73/hour
Intern Professional Rate	\$62/hour
Forensic Rate	\$88/hour
Travel/wait Rate	\$36.50/hour
Mileage Rate	Current State Rate/mile

Fee Caps and Thresholds

As part of the changes to the reimbursement structure, the department has adopted fee caps. Providers must be aware that fee caps are *hard* caps, with *no* exceptions.

At 100 percent of the fee cap, the claim manager can either act directly or request that the Vocational Services Consultant conduct a review of the case. The claim manager may re-refer the case to another Vocational Rehabilitation Counselor or make another appropriate decision, based on the circumstances of the claim, such as the following: making a referral to pension, making a forensic referral, or closing the referral for medical instability reasons.

In situations where the case reaches the fee cap and the department decides another referral is warranted, the case must be started as quickly as possible (within two to three days). Vocational Rehabilitation Counselors must therefore submit closing reports promptly.

When cumulative payments for a referral have reached the cap, the Remittance Advice sent with the payment will contain an Explanation of Benefits, indicating that the referral has reached its fee cap. The department will adjust the amount of the bill to pay *no more* than the fee cap allows and will authorize *no* payment beyond the cap. It is very important that vocational providers work closely with their billing staffs to monitor costs on their referrals.

Please consult the following fee cap table:

Code	Fee Cap	Equiv. VRC Hours ¹	Comments
0800V 0801V	\$1,500 combined	20.5 hours	
0810V 0811V	\$2,500 combined	34.2 hours	
0821V 0823V 0824V	\$1,100		
0830V 0831V	\$5,000 combined	68.5 hours	
0840V 0841V	\$4,725 combined	64.7 hours	
0881V 0882V 0883V 0884V			
0891V 0892V 0893V			
0894V 0895V			Pre-authorization by CM required

Codes

The following table lists the codes, and their corresponding definitions, for use in billing for vocational services. Reimbursement will occur according to the level of provider described below. Separate codes and provider specialties exist for vocational interns, counselors, and forensic examiners.

Example: Intern Y at Acme Rehabilitation bills code 0881V. <u>Result</u>: The department does not pay, because it only authorizes qualified providers to do forensic work.

Code	Description	Counselor Level
	EARLY INTERVENTION	
0800V	Early Intervention Services	VRC
0801V	Early Intervention Services—Intern	Intern

¹ Based on \$73/hour for professional VRC services.

	ASSESSMENT	
0810V	Assessment Services	VRC
0811V	Assessment Services—Intern	Intern
	VOCATIONAL EVALUATION	
0821V	Work Evaluation	VRC
0823V	Pre-job or Job Modification Consultation	VRC
0824V	Pre-job or Job Modification Consultation—Intern	Intern
	PLAN DEVELOPMENT	
0830V	Plan Development Services	VRC
0831V	Plan Development Services—Intern	Intern
	PLAN IMPLEMENTATION	
0840V	Plan Implementation Services	VRC
0841V	Plan Implementation Services—Intern	Intern
	FORENSIC AND TESTIMONY	
0881V	Forensic Services	VRC—
0001 (Totalise Services	Forensic
0882V	Testimony on VRC's Own Work	VRC
0883V	Testimony on Intern's Own Work	Intern
0884V	AGO Witness Testimony	VRC
	OTHER	
0891V	Travel/Wait Time	VRC
0892V	Travel/Wait Time—Intern	Intern
0893V	Professional Mileage	VRC
0894V	Professional Mileage—Intern	Intern
0895V	Air Travel	Intern/VRC/ VRC—
		Forensic

Date Span Information

When providers are completing billing forms, it is very important to include both start and end dates for the date span of services. Providers must include all services provided during this date span on the bill. They may not submit a new bill for additional services during the same date span. If this circumstance occurs, a "Provider's Request for Adjustment "form must be completed to adjust the original charges.

Units of Service

One unit of service equals 6 minutes of time. The stated hourly rate is equal to 10 units of service. The unit of service for mileage reimbursement is per one mile.

Example: the professional VRC rate is \$73 per hour; 1unit of service (6 minutes) pays \$7.30 (\$73.00/10); 2 units of service (12 minutes) pays $2 \times $7.30 = 14.60

Referral Identification Number on Bills

When completing billing forms, a provider must include the referral identification numbers for each submitted bill. The department will deny payment for any bill submitted without a referral identification number. Each department referral has a unique referral identification number.

Documentation

Documentation that supports billing includes the provider's case notes. Providers should ensure that their case notes include evidence of the time spent on various activities. **Example:** A provider who spends a half-hour on a progress report for a case might specify that half-hour in <u>his or her</u> case notes as ".5 hours preparing progress report."

Travel/Wait and Mileage

The department developed separate codes for vocational providers' travel/wait time. The department pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The department does NOT pay for travel time between two different service locations or branch offices where a provider is working cases.

Providers should bill from the branch office where the referral has been received by the VRC to necessary destinations, such as the following: going to the location of the employer of record, visiting an attending physician's office, and the meeting of a VRC with an injured worker at his or her home.

Example: A vocational counselor indicates to the department that he or she is willing to work referrals in Seattle, Yakima, and Longview.

Result: The department will reimburse the provider for travel/wait time on cases in each of these three areas, but will not pay for the provider to drive from Seattle to Yakima, or from Longview to work a Seattle or Yakima referral.

Travel/wait is reimbursed at 50% of the standard vocational counselor rate, regardless of referral type or provider specialty. Travel/wait must be pro-rated if more than one referral is included in a particular trip.

Mileage, as determined by the federal rate, is reimbursed at the same rate as that of travel on state business. The department reimburses mileage at the same rate, regardless of referral type or provider specialty.

For More Information

The **Internet address** where information is available is as follows:

http://www.lni.wa.gov/rules/

Obtaining a Copy of the Vocational Rehabilitation Rules

Providers can obtain a copy of the rules governing vocational services (WAC 296-19A) through the Internet at the following address:

http://www.lni.wa.gov/rules/voc%20rehab/vocrehabcr103.htm

COMPLETING THE "STATEMENT FOR MISCELLANEOUS SERVICES" FORM

The Department of Labor and Industries and service providers are joined in a cooperative process for payment of provider billings. In order to process the billings in a timely manner, the billings must be completed as described. Improperly completed bill forms may be returned to the provider for completion/correction and resubmission.

Completed bill forms MUST be typed or printed and be clearly legible. Bills must be submitted on <u>ORIGINAL</u> (not photocopies or facsimiles) Statement for Miscellaneous Services forms. All boxes on the form other than those identified, as "not applicable" MUST be completed to ensure correct bill adjudication.

DO NOT STAPLE ANY ATTACHMENTS IN THE BAR CODE AREA AT THE TOP OF THE FORM.

All boxes on the form other than those identified, as "not applicable" <u>must</u> be completed in order to ensure correct bill adjudication.

- 1. Check the box indicating the applicable category of service. If your particular service category is not listed, check the "OTHER" box (e.g., interpreter services and licensed massage therapists would check the "other" box).
- 2. **WORKER'S NAME:** Enter worker's last name, first name and middle name or initial.
- 3. **SOCIAL SECURITY NUMBER:** Enter worker's social security number. This information will assist us in identifying the injured worker's claim number if the claim number is missing or invalid.
- 4. **CLAIM NUMBER:** Enter the department-assigned claim number for the injury/condition being treated. Omission of this number will result in denial of payment.

Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source, which is listed below.

STATE FUND INDUSTRIAL INSURANCE Claim numbers are six digits, preceded by the letter "B, C, F, G, H, J, K, L, M, N, P, X or Y". Effective 1/1/2000, Department of Energy (DOE) claims are administered by Self-Insurance. All other DOE claims previous to 1/1/2000, are administered by the State Fund. DOE claims have seven digits with <u>no</u> preceding letter.

Send bills for State Fund claims to

Department of Labor and Industries PO Box 44267 Olympia WA 98504-4267 CRIME VICTIMS Crime Victims' Compensation Program claim numbers are either six digits preceded by a "V," or five digits preceded by a "VA, VB, VC, VH or VJ".

Send Bills for Crime Victims claims to

Department of Labor and Industries Crime Victims Compensation Program

PO Box 44520

Olympia WA 98504-4520

SELF-INSURANCE Self-Insurance claim numbers are six digits preceded by an "S, T or W." Bills for all Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

- 5. **ADDRESS:** Enter worker's current address.
- 6. **EMPLOYER'S NAME:** Enter worker's employer's name.
- * **REIMBURSE INJ WORKER:** Check applicable box indicating whether the injured worker has paid for the services.
- 7. **DATE OF INJURY/ILLNESS:** The date of injury/illness positively identifies each claim. This is important and **must** be included. A worker may have several claims; therefore, it is vital that the proper claim be identified and charged for services provided.
- 8. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:** Enter name of the doctor referring claimant to you, if applicable.
- 9. **REFERRING PHYSICIAN PROVIDER NUMBER:** Enter L&I provider account number of referring doctor.
- 10. **DIAGNOSIS:** ICD9-CM code is not required. However, you <u>must</u> provide a narrative description, e.g., broken glasses, left eye injury, left leg injury, etc. <u>Designate left or right side of body, when applicable.</u>
- 11. **FOR GLASSES:** Indicate "yes" or "no," if applicable to service being provided.
- 12. **SERVICES RELATED TO HOSPITALIZATION:** Not applicable.
- 13. ITEMIZATION OF SERVICES AND CHARGES:
 - A. **DATE OF SERVICE:** Record one date of service per line.
 - B. **PLACE OF SERVICE:** Enter required 2-digit place of service code. See list of codes in the *Place of Service* section of this booklet or on the reverse side of the bill form.
 - C. **TYPE OF SERVICE:** Enter appropriate type of service code. See list of codes on the last page of this booklet or on the reverse side of the bill form.

- D. **PROCEDURE CODE:** This code identifies the procedures performed or items provided (CPT/HCPCS/Local Code). The department's **Medical Aid Rules and Fee Schedules** lists the procedure code. Enter <u>only one code per line</u>.
- E. **PROCEDURE CODE MODIFIER:** Use only if applicable to your provider type and service provided. Modifiers are listed in the RBRVS section of the current fee schedule.
- F. **DESCRIBE PROCEDURES:** Enter brief description of services or supplies furnished.
- G. **DENTAL TOOTH NUMBER:** Enter tooth number. (Dental Services use only)
- H. **HOME NURSING:** Enter number of hours. (Home Nursing Services use only)
- I. **GLASSES:** Complete this box as indicated. (Optometrist & Optician use only)
- J. **CHARGES:** Total line item charge. (Do not bill negative charges.)
- K. **UNIT:** Enter the total number of days, units, total hours, or miles for the services billed on a line: e.g., rental, lodging, multiple packages of supplies, transportation, etc.
- 14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** Enter the name of the provider providing the services (enter last name first) and current address. If there are any changes in the provider's address or status, immediately notify Provider Accounts in writing or via fax at the following address/fax number:

Provider Accounts Department of Labor and Industries PO Box 44261 Olympia WA 98504-4261 Fax 360-902-4484

PLEASE INCLUDE THE L&I PROVIDER ACCOUNT NUMBER(S) THAT YOU'RE SUBMITTING A CHANGE FOR ON YOUR CORRESPONDENCE.

Indicating a new address on the bill will not change the department's record of your

Indicating a new address on the bill will not change the department's record of your address and could delay payment.

- 15. **PROVIDER NUMBER:** Enter the L&I provider account number assigned by the department for the provider of service.
- 16. **TOTAL CHARGE:** Total of **all** charges for services provided.
- 17. **YOUR PATIENT'S ACCOUNT NUMBER:** The number you use to identify your patient's account. This number is for your convenience only.
- 18. **BILL DATE:** The date your billing was prepared.
- 19. **REMARKS:** Enter any further information necessary to explain your charges.
- 20. **REFERRAL ID:** Enter appropriate referral identification number.

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STATEMENT FOR MISCELLANEOUS SERVICES

INSTRUCTIONS FOR COMPLETING MISCELLANEOUS SERVICES FORM

- Place an "X" in the box next to the type of service for which you are billing.
- CLAIM NUMBER: For the injured worker receiving services.

INDUSTRIAL Claim numbers are six digits, preceded by a "B, C, F, G, H, J, K, L, M, N, P, X or Y." Crime victim claim numbers are six digits preceded by a "V",

INSURANCE Send bills for Industrial Insurance claims to: Send bills for Crime Victims claims to:

> Department of Labor and Industries Department of Labor and Industries PO Boy 44267 PO Boy 44520

Olympia WA 98504-4267 Olympia WA 98504-4520

SELE Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department service location. INSURANCE Self-insurance claim numbers are six digits preceded by an "S. T or W". Bills for all self-insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

- INJURED WORKER'S NAME: Injured worker's full name, last name first. 3.
- SOCIAL SECURITY NUMBER: Record claimant's social security number. It helpful when the claim number is wrong and the worker's name is common.
- ADDRESS: The injured worker's most current address. 5
- EMPLOYER'S NAME: The injured worker's employer's name. If the claim number is in error, this helps identify the pro per claim. 6.
- DATE OF INJURY: This is important and must be included. One worker may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
- 8. NAME OF REFERRING PHYSICIAN: The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing)
- REFERRING PHYSICIAN PROVIDER NUMBER: The Department of Labor and Industries provider account number of the referring physician. The number may be 9. Obtained from the referring physician. (Not applicable for Vocational Services billing.)
- 10. DIAGNOSIS: Indicate both the ICD9-CM number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The Diagnosis presented must be specific. (Not applicable for Vocational Services billins.)
- FOR GLASSES: Indicate by placing an "X" in the appropriate box. 11
- SERVICES RELATED TO HOSPITALIZATION: If claimant was hospitalized, record the date admitted and the date discharged.
- ITEMIZATION OF SERVICES AND CHARGES: 13.
 - DATE(s) OF SERVICE: Record the date for each service provided. For consecutive dates of service (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
 - B. PLACE OF SERVICE: Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
 - TYPE OF SERVICE: A complete list of Type of Service (TOS) codes is printed below. Please refer to that list and place the appropriate code in the space provided.
 - D. PROCEDURE CODE: Identifies the procedure used. Procedure codes can be found in the Medical Aid Rules and Maximum Fee Schedule distributed by the Department of Labor and Industries
 - F. CODE MODIFIER: A modifier provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
 - F. **DENTAL:** To be used for dental services only

Tooth Number: Identify dental services provided by placing the specific tooth number in the appropriate box.

HOME NURSING: To be used for home care only. G.

Number of Hours or Day: Identify the number of hours or the number of days that the home care services were provided.

Hourly or Daily Rate: Record the rate charged (by the hour or day) for the home care services provided.

GLASSES: To be used for glasses repair or replacement only H.

Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.

- New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
- ı. CHARGES: Charges for services provided.
- UNIT: The sum total services provided for days, units, or miles, etc.
- PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER: The provider's or supplier's name and current address. If any of the 14 information changes, notify Provider Accounts immediately. (Indicating a new address on the bill will not change the department's record of address for the provider.
- PROVIDER NUMBER: Identification number designated by the Department of Labor and Industries for the provider. 15.
- TOTAL CHARGE: Total of all charges for services provided. 16.
- 17 YOUR PATIENT'S ACCOUNT NUMBER: The number used to identify your patient's explanation.
- REMARKS: Any information necessary that the provider or supplier feels is necessary for further explanation. 18.

ATTACHMENTS

The following attachments **must be** submitted with billings for appropriate services:

1. X-ray findings

5. Emergency Room reports

2. Lab reports 6. Diagnostic Study reports 3. Office notes Cost invoice of supplies furnished 4 Operative reports 8 Consultation reports

Each attachment must have the corresponding claim number I isted in the upper right corner of the attachment.

DUE TO THE FACT THAT THE DEPARTMENT RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR. The following attachment is not acceptable: Office Visit Slips.

REBILLS

If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill; same charges, codes and billing dates. Please indicate "Rebill" on the bill.

Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

PLACE OF SERVICE (POS)

1. Inpatient Hospital 5. Emergency Room 6. Other Medical/Surgical Facilities 2. Outpatient Hospital

Office Nursing Home 4 Residence 8 Other Location

TYPE OF SERVICE (TOS)

C Chiropractic Services
D Drugless Therapeutics

Inpatient

N Nurse Practitioner Services

O Outpatient

P Physical Therapy

V Vocational Services

3 Medical Services

Dental

 Ancillary Services (attendant, equipment, glasses)

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Any City				State WA	98512			Reimburse Injured Worke		Yes	X No		Amount Paid \$				
Date of Injury	ίX				physician or other so							Referring p	hysician prov	ider num	ber		
DIAGNOSIS OR (use ICD-9-CM) 1. XXX.X 2. 3. 4.	Designa					For glasses, advise if old Available? Ye Give hospitalization date Services Admitted/ Discharged/	es			I here true a incur paym	and correct cla red by me, tha	der penalty of paim for the neo at the claim is journed by m	essary exper just and due a	rjury that this is a ssary expenses st and due and that no on account thereof.			
FROM DATE OF SERVICE	P O S	T 0 S	PROC CODE	MOD CODE	supplies furnished.	es, medical services, or Attach lab reports, any special services.	Dental Tooth Numbe		e Nursir		Gla OLD RX	sses NEW RX	Charges \$	Unit	TO DATE OF SERVICE		
3/1/01	XX	N	XXXXX		X-ray lindings and	any special services.	Numbe	hrs/day	Hou Day	rate	OD OS	OD OS	XX.XX	X	3/1/01		
Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid. Signature: Bill date: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW					Provider or Supplier name XXXXXX XXX RNFA Address 123 E 5 th Ave City City State VA 00000-0 Federal tax ID number					Your Pati Account	umber XXX-XXX ent's		STATE OF STA				

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NO STAPLES BAR CODE AI DO NOT WRITE IN SPACE		Medical Equipment/ Vocati									Glasses Vocation Retrainin Other					
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 * Place of Service (POS) and Type of Service (TOS) codes on back

Referral ID

NO STAPI BAR COD		<u>.</u>					PO Bo	x 44267	and Indu		,				Services Equipment/		Glasse	
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XX-XX-> DIAGNOSIS OR	NATUR		ILLNESS OR	INJURY	XXXXXXX	For glasses, a	dvise if old	Rx was				REF	UND C	ERTIF	XXXX ICATION	XXXX		
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OF SERVICE	0	0	CODE	CODE	supplies furnished X-ray findings and	. Attach lab repo	orts,	Toot	h oer No	o of s/day	Hou	rly	OLE OD	RX	NEW RX OD OS	\$	Onit	OF SERVICE
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Submission of this expenses incurred,						XXXXX	X XXX			XX	XXX	XX	-		XXX		_	ETA
bill is a true and co is just and due; that	rrect cha	rge ag	ainst the State of	of Washingto paid.	on; that the claim	Address 123 E 5	5 th Ave						(X	(XX)	umber XXX-XXX	<u> </u>	(1)	
Signature:	\	./\/		Bill d	ate: MM / DD / YY	Any Cit	ty			tate 000	ZIP + 4		Ac		ent's Number			1889
Remarks:	VVV	v v		ľ		Federal tax XX-XXXXX	XX or	•		EIN	s	SN	┤^	^^^	·//////	\ \\\		
F245-072-000	statem	ent f	or misc servic	ces 4/01	* Place of	f Service (POS)		of Servi	ce (TOS)) codes	on bacl	k	Re	eferral	ID			

NO STAPLES IN BAR CODE AREA

Dept of Labor and Industries PO Box 44267

Dental Services

Medical Equipment/
Prosthetics-Orthotics

Transportation

Transportation

WRITE IN SPACE

SAMPLE DRUG & ALCOHOL

_							1	23-45-	Number	à	• /		Y 00	ሰሰሰሰ	1
Last Doe			Johr	า	А	L				9			1 00	0000	
Address 123 E 5 ^t	h Ave	Э						MBC En		yer					
Any City	,			State	98512			eimburse jured Worker		Yes	X No		Amount Paid \$		
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FROM DATE OF SERVICE	P O S	T 0 S	PROC CODE	MOD CODE	supplies furnished.	es, medical services, or Attach lab reports, any special services.	Dental Tooth Number	No of	Nursing	у	OLD RX	SSES NEW RX	Charges \$	Unit	TO DATE OF SERVICE
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Submission of this expenses incurred, bill is a true and co	or other i orrect char	tem of ge aga	f indebtedness a ainst the State of	s charged in f Washingto	the foregoing	Address 123 E 5 th Ave					Phone N	umber XXX-XXX	ζ		E STATE
is just and due; tha Signature:	t no part	of the	same has been j	paid. Bill da	ate:	City			ZIP + 4		Your Pati Account			SAL O	
VVVVV Remarks:	/ ////	/ V		N	MM / DD / YY	Any City Federal tax ID number		WA 000	1			(XXXXXX)	XXX	×	1889 80
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NO STAPLE BAR CODE						PO Bo	of Labor a ox 44267 oia WA 9		ndustries	~		Dental Se	ervices		Glasses	·
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DO NOT WRITE IN SPACE		5	SAMPLE	E LMT								I Home He			Other	
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Address 123 E 5 ^{tl}	h Ave	е							ployer's Nan BC En		yer					
City Any City				State	98512			Rei	mburse red Worker		Yes	X No		Amount Paid \$		
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Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is justified the; that no part of the same has been paid.

Bill date:

 $MM \, / \, \, DD \, / \, YY$ VVVVVVVVVVV

Provider or Supplier name Total Charge XXXXX XXX LMT \$ XX.XX **XXXXXX** Phone Number 123 E 5th Ave (XXX) XXX-XXXX Your Patient's Account Number State ZIP + 4 Any City WA 00000-0000

Federal tax ID number XX-XXXXXXX or

EIN [

XXXXXXXXXXX

Referral ID

XXX-XX-XXXX* Place of Service (POS) and Type of Service (TOS) codes on back



NO STAPLES IN		Dept of Labor and Industries			
BAR CODE AREA		PO Box 44267 Olympia WA 98504-4267	Dental Services		Glasses
			Medical Equipment/ Prosthetics-Orthotics		/ocational/ Retraining
			Transportation	X	Other
O NOT	SAMPLE NURSE CASE MGMT		Home Health/		

PACE										→ Nursing	Home Service	:S		
WORKER'S NA		ULL	First			ddle		ocial Security 1 123-45-0	•	ID only)		Y 00)
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City Any City	1			State WA	98512			Reimburse njured Worker	Yes	X No		Amount Paid\$		
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3/1/01	XX	9	1220M		Phone Cal	ls		hrs/day	Day rate	OD OS	OD OS	xx.xx	Х	4/1/01
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3/1/01	XX	9	1222M		Case Plan							xx.xx	Х	4/1/01
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ubmission of this expenses incurred, ill is a true and co is just and due; that	or other	item o rge ag	f indebtedness a ainst the State of	ns charged in f Washingto	the foregoing	123 E 5 th Ave	/e State ZIP + 4				XXX-XXX	<		e state
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						XX-XXXXXXX or XXX-XX-XXXX		EIN	SSN	Referral	ID			
F245-072-	000 sta	temer	nt for misc ser	vices 4	'01 * Place	e of Service (POS) and T	ype of Serv	rice (TOS) cod	es on back	Neiciial				34

			STATEMENT FOR	IVII	CELLANEOU	ט ט	LIVICE
	NO STAPLES IN BAR CODE AREA		Dept of Labor and Industries PO Box 44267 Olympia WA 98504-4267		Dental Services		Glasses
					Medical Equipment/ Prosthetics-Orthotics		Vocational/ Retraining
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WRITE IN >		<u>S</u>	<u>SAMPLI</u>	E OBE	<u>ESITY TR</u>	<u>EATMENT</u>						lome He Jursing H	alth/ Home Service	s			
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						XX-XXXXXXX or XXX-XX-XXXX		L	EIN _	SSN		Oforral 1	D				
F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (POS)								Servic	e (TOS) cod	les on back		Referral ID 35					

NO STAPLES IN Dept of Labor and Industries BAR CODE AREA PO Box 44267 Dental Services Glasses Olympia WA 98504-4267 Medical Equipment/ Vocational/ Prosthetics-Orthotics Retraining Transportation X Other DO NOT SAMPLE OCCUPATIONAL THERAPY Home Health/ WRITE IN SPACE Nursing Home Services WORKER'S NAME IN FULL Middle Social Security Number (for ID only) Claim Number 123-45-6789 Y 000000 Doe John Last Employer's Name Address 123 E 5th Ave **ABC Employer** State ZIP Reimburse Amount X No Injured Worker Paid\$ Any City WA 98512 Date of Injur Name of referring physician or other source Referring physician provider number XX-XX-XX XXXXX XXXXXXXX MD XXXXXX DIAGNOSIS OR NATURE OF ILLNESS OR INJURY or glasses, advise if old Rx was REFUND CERTIFICATION I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses (use ICD-9-CM) Designate left or right when applicable. Available? Yes incurred by me, that the claim is just and due and that no 2. Give hospitalization dates for inpatient payment has been received by me on account thereof. Services CLAIMANT'S SIGNATURE: 3. Admitted 4. Discharged FROM DATE TO DATE Describe procedures, medical services, or Dental Home Nursing Glasses MOD CODE Charges Unit PROC OF SERVICE 0 0 supplies furnished. Attach lab reports, Tooth OF SERVICE OLD RX NEW RX S S X-ray findings and any special services. Number No of Hourly hrs/day Day rate OD OS OD OS 3/1/01 97003 Occupational Therapy Χ 3/1/01 9 XX XX.XX Eval CPT codes and descriptions are © 2000 American Medical Association

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid. Signature: Bill date:

MM / DD / YY

Provider or Supplier name Provider number Total Charge XXXXX XXX OT \$ XX.XX **XXXXXXX** Address Phone Number (XXX) XXX-XXXX 123 E 5th Ave Your Patient's State ZIP + 4 Account Number

WA 00000-0000 Any City Federal tax ID number EIN SSN

XXXXXXXXXXX

Referral ID

* Place of Service (POS) and Type of Service (TOS) codes on back

XX-XXXXXXX or XXX-XX-XXXX



VVVVVVVVVVV

Remarks:

NO STAPLES IN BAR CODE AREA	

Dont of Labor and Industries		
Dept of Labor and Industries PO Box 44267 Olympia WA 98504-4267	Dental Services	Glasses
	Medical Equipment/ Prosthetics-Orthotics	Vocational/ Retraining
	Transportation	X Other
	Home Health/ Nursing Home Services	

WORKER'S NAM	ME IN FL	JLL	First		ľ	Middle			ial Security N 23-45-6			only)		Y 000		
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OF SERVICE	0 S	O S	CODE	CODE		d. Attach lab reports, d any special services.	n er	No of	Hourl			NEW RX	\$		OF SERVICE	
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Submission of this expenses incurred, bill is a true and co	or other i	item o	f indebtedness a	s charged in	the foregoing	Address 123 E 5 th Ave	Phone Number					s STATE OF				

is just and the; that no part of the same has been paid. Bill date:

VVVVVVVVVV MM/DD/YY Remarks:

State ZIP + 4 Your Patient's Account Number City Any City WA 00000-0000 XXXXXXXXXXX Federal tax ID number XX-XXXXXXX or EIN SSN

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XXX-XX-XXXX * Place of Service (POS) and Type of Service (TOS) codes on back



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NO STAPLES IN BAR CODE AREA					Dept of Labor and Industries PO Box 44267 Olympia WA 98504-4267			Dental Services Medical Equipment/ Prosthetics-Orthotics			Glasses Vocational/ Retraining				
					Ciyilipia WA 96304-9207										
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DO NOT WRITE IN SPACE		5	SAMPL!	E VO	CATIONA	AL REBAB SEI	RVICE	<u>S</u>			Home Hea Nursing H	Ith/ ome Services			
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XX-XX->		E OF			XXXXXX	X MD For glasses, advise if old	l Rx was			REF	UND CERTIF	TICATION	XXXX		
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2.						Give hospitalization date Services	s for inpatie	nt				n received by r			Ю
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4. 5•						Discharged /	/								
FROM DATE OF SERVICE	P 0	T O	PROC CODE	MOD CODE	supplies furnishe	ures, medical services, or ed. Attach lab reports,	Dental Tooth		Nursin	•		isses	Charges \$	Unit	TO DATE OF SERVICE
2/1/2/	S	S	00001/		, ,	nd any special services.	Number	No of hrs/day	Hou Day		OLD RX OD OS	NEW RX OD OS			2/1/2/
6/1/01	XX	V	V0080		Early Inte	ervention Svc							XX.XX	Х	6/1/01
6/1/01	XX	V	0810V		Assessm	ent Services							XX.XX	Х	6/1/01
6/1/01	хх	V	0830V		Plan Deve	elopment Svcs							XX.XX	Х	6/1/01
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						Provider or Supplier na	ame	I Prov	/ider nu	mher	Total Ch	arge		<u> </u>	
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Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is jsshared the; that no part of the same has been paid. Bill date:

VVVVVVVVVV MM/DD/YY

Voc Rehab Counselor \$ XX.XX **XXXXXXX** Phone Number 123 E 5th Ave (XXX) XXX-XXXX Your Patient's Account Number Any City WA 00000-0000 XXXXXXXXXXX Federal tax ID number

EIN SSN

Referral ID

XXXXXXXXX



 * Place of Service (POS) and Type of Service (TOS) codes on back

XX-XXXXXXX

F245-072-000 statement for misc services 4/01

Remarks:

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NO STAPLES IN BAR CODE AREA					ox 44267	r and Industries 7 98504-4267			Dental Services				Glasses			
											Medical Equ				Vocation Retraining	
											Transporta	tion			Other	
DO NOT WRITE IN SPACE		<u> </u>	<u>SAMPLI</u>	E VO	CATIONA	AL REBAB SE	<u>RVI C</u>	<u>ES</u>			Home Healt Nursing Ho		vices			
WORKER'S NAI	ME IN F	JLL	First	t	1	Middle		Social Security 123-45-			D only)			Claim Number Y 00000		
Last Doe Address			Johi	n	,	A				9				1 00	0000	,
123 E 5 ^t	h Av	е						ABC Er		yer	•					
Any City	,			State WA	98512			Reimburse Injured Worker		Yes	X No			Amount Paid\$		
Date of Injury					physician or other		I						rring phy	ysician prov	vider num	ber
DIAGNOSIS OR (use ICD-9-CM) 1.						For glasses, advise if of Available? You Give hospitalization date Services	es 🗌	REFUND CERTIFICATION I hereby certify under penalty of perjury that this is true and correct claim for the necessary expenses incurred by me, that the claim is just and due and to payment has been received by me on account their						ry that this is a ary expenses and due and that no		
3. 4. 5.						Admitted/				CLA	IMANT'S SIGN	NATURE	:			
FROM DATE OF SERVICE	P O S	T 0 S	PROC CODE	MOD CODE	supplies furnishe	ures, medical services, or d. Attach lab reports,	Denta Tooth	ı	Nursin	•	Glas			Charges \$	Unit	TO DATE OF SERVICE
0/4/04			00041/			d any special services.	Numbe	er No of hrs/day	Hou Day		OLD RX OD OS	NEW OD	os			0/4/04
6/1/01	XX	V	0801V		Intern	vention Svc -								XX.XX	Х	6/1/01
6/1/01	XX	V	0811V		Assessme Intern	ent Services –								XX.XX	Х	6/1/01
6/1/01	xx	V	0824V		Pre-job or	Job Modification	Cons	ultation -	Inter	n				XX.XX	Х	6/1/01
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Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid. Bill date:

VVVVVVVVV MM / DD / YY

Provider or Supplier name Total Charge Provider number \$ XX.XX Voc Rehab Intern **XXXXXX** Phone Number 123 E 5th Ave (XXX) XXX-XXXX Your Patient's Account Number State ZIP + 4 Any City WA 00000-0000 XXXXXXXXXXX Federal tax ID number EIN SSN XX-XXXXXXX

Referral ID

XXXXXXXXX



F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

39

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NO STAPLES IN BAR CODE AREA						PO Bo	of Labor ar ox 44267 pia WA 98	nd Industries 504-4267			Dental Ser	vices		Glasses	
											Medical Eq Prosthetic	uipment/ s-Orthotics	X	Vocation Retraining	
											Transporta	ation		Other	
DO NOT WRITE IN SPACE		<u> </u>	SAMPLI	E VOC	CATIONA	AL REBAB SE	RVIC	<u>ES</u>			Home Heal Nursing Ho	th/ ome Services			
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Any City	,			State WA	98512			Reimburse Injured Worker		Yes	X No		Amount Paid \$		
Date of Injury				of referring	physician or other								hysician prov	rider num	ber
DIAGNOSIS OR	NATUR		ILLNESS OR	INJURY	XXXXXX	For glasses, advise if old	d Rx was				UND CERTIF				
(use ICD-9-CM) 1.	Designa	ate lei	t or right when	applicable.		Available? Ye	es 🗌	No		true	and correct cla	der penalty of paim for the neo at the claim is j	essary exper	nses	0
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Bill date:

MM / DD / YY

Voc Rehab Councelor XXXXXX \$ XX.XX Forensic Phone Number 123 E 5th Ave (XXX) XXX-XXXX Your Patient's Account Number State ZIP + 4 Any City WA 00000-0000 XXXXXXXXXXX Federal tax ID number

EIN SSN

Referral ID

XXXXXXXXX

 * Place of Service (POS) and Type of Service (TOS) codes on back

XX-XXXXXXX



F245-072-000 statement for misc services 4/01

VVVVVVVVVVV

Remarks:

40

REBILLS

REBILLS should be submitted when:

Your TOTAL BILL has been denied.

Your bill was sent in over 60 days ago and is not yet showing up on your Remittance Advice

You are **required** to REBILL: (WAC 296-20-125)

- For TOTAL BILLS denied because the claim was closed and the claim has now been reopened
- For TOTAL BILLS denied because the claim was first rejected and the claim has now been allowed.
- For TOTAL BILLS denied because a diagnosis was at first not allowed and the diagnosis has now been allowed

Rebills must be <u>received</u> at the department **within one year of the date the final order was issued** which reopened or allowed the claim or diagnosis.

A Rebill should be identical to the original bill: same charges, codes and dates of service. Rebills should be submitted on new ORIGINAL bill forms. We cannot process photocopies or facsimiles.

ADJUSTMENTS

A "Providers Request for Adjustment" form (F245-183-000) should be submitted to correct an incorrect field on a bill that has already processed and partially paid.

Enter the workers name (field 1), their claim number as it appears on your REMITTANCE ADVICE (field 2), the correct claim number if applicable (field 3), the providers name and address (field 4), the ICN (internal control number) of the bill (field 5) as it appears on your REMITTANCE ADVICE (see example headings below for location of the ICN as it appears on your REMITTANCE ADVICE), the performing providers L&I provider number (field 6) and L&I payee number (field 7), if applicable.

					Service	Dates			Billed
Claim #	Name	I	Patient Acct#	ICN	From	То	Unit	Procedure	Charge
P000000	XXXXXXX	Х	XXXXXXXXX	09936425045000200	121399	121799	1	XXXXX	XX.XX

In the body of the form (field 8) correct only those line item fields that have been paid or denied incorrectly due to incorrect information. Enter only the corrected information (as it should have appeared on the original bill) in the line item fields corresponding to the line item fields on your bill as it appears on your REMITTANCE ADVICE.

EXAMPLE:

You billed one unit of service on line one but four units were actually completed and should be payable. You've only been paid for one unit. Everything else on the bill is correct. In field 8, on line one of the adjustment form, enter '4' in the 'unit' field. After the adjustment processes you will receive payment for the three units previously unpaid.

Please attach to the adjustment form a copy of your ORIGINAL BILL and a copy of the page of your REMITTANCE ADVICE where your paid bill appears.

Request for Reconsideration on adjustments initiated by the department

Per legal notice on your REMITTANCE ADVICE, a request for reconsideration of a payment must be made in <u>writing</u> within 20 days of receipt of notice of the adjustment/deduction.

The basis for the request for reconsideration must be other than an objection to the payment amount established by the departments fee schedule.

All supporting documentation relevant to the reconsideration request must be submitted with the request.

Note:

DO NOT SUBMIT an adjustment or a rebill for a bill that is reported "in process" on your Remittance Advice. If the bill remains in the "in process" status for **over 60 days**, call our Provider Hotline at 1-800-848-0811. For bills "in process" **under 60 days** you may access the Claim Information Line by calling 1-800-831-5227. Once you access the 'in process' bill information, you may choose the 'zero' option to be connected to the bill payment section.

Adjustments will appear as the last item on the Remittance Advice as follows:

(See sample RA on page 38)

Your original bill will be reprinted, appearing as a credit for the amount previously paid, (e.g., \$100.00 - CRE).

Your adjustment will usually appear immediately following the credit of your bill.

If an additional payment is allowed, the total amount allowed for the bill will be reported (e.g., \$125.00). The difference between original and adjusted payment will be paid in the warrant (e.g., \$25.00).

If no additional fee is allowable, the amount of the adjustment will be equal to the credit of the previous payment (e.g., \$100.00).

If the original payment is being recouped, the total or partial amount allowed for the bill will be reported (e.g., \$0.00). The "adjusted payment" will recoup the original amount of the bill and report the difference as a credit, CRE (monies owed back to the department).

NO STAPLES IN BAR CODE AREA



PROVIDER'S REQUEST FOR ADJUSTMENT

CHECK→ ONE	TOTAL OVERPAYMENT PARTIAL OVERPAYMENT UNDERPAYMENT
---------------	--

DO NOT WRITE IN SPACE Please type or print in dark ink ENTER DATA FROM ORIGINAL REMMITTANCE ADVICE INSTRUCTIONS ARE ENCLOSED 2) CLAIM NUMBER ON REMIT ADVICE 3) CORRECT CLAIM NUMBER 1) WORKERS NAME (Last, First, Middle) 4) PROVIDER NAME AND ADDRESS 5) ICN NUMBER ON REMITTANCE ADVICE 6) PROVIDER NUMBER 7) PAYEE NUMBER COMPLETE ONLY THOSE LINE ITEMS PAID/DENIED IN ERROR - ENTER ONLY CORRECTED INFORMATION 8) Line f) ICD-9-CM i) Days/ e) CODE g) Tooth j) Days a) From/to Date of Service Description d) Procedure Code/ Diagnosis/ Side of Body Units/ Charge MOD or Covered Dates Revenue Code/NDC Number Quantity Supply Item 01 02 03 04 05 06 07 08 09 10 11 12 13 14

9. OTHER REMARKS/JUSTIFICATIONS/SPECIAL CIRCUMSTANCES - ATTACH REQUIRED REPORTS - EXPLAIN FULLY

DATE	SIGNATURE OF PERSON COMPLETING FORM	PHONE NUMBER
		()

SAMPLE PAGE BLMC8000-R001 AS OF 03/28/2001

DEPARTMENT OF LABOR AND INDUSTRIES OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE ZIP

CITY, STATE ZIP			
PAYEE PROVIDER NUMBER 0000000 REMIT ADVICE # XXXXXX W	ARRANT REGISTER NUMBER 60	048 DATE 03/30/2001 PAGE	X
CLAIM NAME I PATIENT ICN NUMBER ACCT/RX NUMBER	SERVICE DATES UNIT FROM TO OF SVC	PROCEDURE BILLED ALLO REVENUE CHARGES NDC	WED TAX OR PAYABLE EOB NON- CODES COVD CHARGES
PAID BILLS - MISCELLANEOUS BILL Y000000 XXXXXXX X XXXXXXXXXX 00111525045000200	011301 011701 1 011301 011701 1 011301 011701 1 011301 011701 1 ***BILL TOTAL	XXXXX XX.XX XX. XXXXX XX.XX XX. XXXXX XX.XX XX. XXXXX XX.XX XX. XXXXX XX.XX XX.	XX 0.00 XX.XX XX 0.00 XX.XX XX 0.00 XX.XX
***PAID BILLS TOTAL - MISCELLANEOUS BILLS	**NUMBER OF BILLS	1 XX.XX XX.	
BILLS-IN-PROCESS - MISCELLANEOUS BILL X000000 XXXXXXXX X XXXXXXXXXX 00111525030003700	012201 012201 1 012201 012201 2 ***BILL TOTAL *****	XXXXX X.XX X.X XXXXX XX.XX XX. XX.XX XX.	XX 0.00 XX.XX
***BILLS PENDING TOTAL – MISCELLANEOUS BILLS	***NUMBER OF BILLS-	1 XX.XX 0.0	0.00 0.00
DENIED BILLS – PRACTITIONER BILL X000000 XXXXXXX X 321 00111525004006000 ***DENIED BILL TOTAL – MISCELLANEOUS BILLS	012101 012501 1 012101 012501 1 012101 012501 1 ***BILL TOTAL***** ***NUMBER OF BILLS-	##M## XX.XX 0.0 ###A# XXX.XX 0.0 M#### XXX.XX XXX XXX.XX XXX 1 XXX.XX XXX	00 0.00 0.00 045 .XX 0.00 XXX.XX .XX 0.00 XXX.XX
		. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ADJUSTMENT – BILLS - MISCELLANEOUS BILL X000000 XXXXXXX X 321 00111725007101500	012101 012501 1 012101 012501 1 012101 012501 1 ***BILL TOTAL*****	##M## XX.XX- 0.0 ###A# XXX.XX- 0.0 M#### XXX.XX- XXX. XXX.XX- XXX.	0- 0.00 0.00- XX- 0.00 XXX.XX-
X000000 XXXXXXX X 321 00111725007201500	012101 012501 1 012101 012501 1 012101 012501 1	M#### XX.XX XX. A#### XXX.XX XXX M#### XXX.XX XXX	.XX 0.00 XXX.XX .XX 0.00 XXX.XX
ADJUSTMENT TOTALS – MISCELLANEOUS BILL	*BILL TOTAL***** **NUMBER OF BILLS -	2 XXX.XX XXX 2 XXX.XX XXX	

TYPE OF SERVICE CODES:

Physical Therapy C Chiropractic Services P **Drugless Therapeutics** D V **Vocational Services** Inpatient 3 **Medical Services** I **Nurse Practitioner Services** N 4 Dental

O Outpatient 9 AncillaryServices (attendant, equipment, glasses)

PLACE OF SERVICE CODES:

- 11. Office
- 12. Patient's Home
- 21. Inpatient Hospital
- 22. Outpatient Hospital
- 23. Emergency Rm Hospital
- 24. Ambulatory Surgical Ctr
- 25. Birthing Ctr
- 26. Military Trmt Facility
- 31. Skilled Nursing Facility
- 32. Nursing Facility
- 33. Custodial Care Facility
- 34. Hospice
- 41. Ambulance Land
- 42. Ambulance Air or Water
- 50. Federally Qualified Hlth Ctr
- 51. Inpatient Psychiatric Facility
- 52. Psychiatric Facility Partial Hospitalization
- 53. Community Mental Health Ctr
- 54. Intermediate Care Facility/Mentally Retarded
- 55. Residential Substance Abuse Trmt Facility
- 56. Psychiatric Residential Trmt Ctr
- 60. Mass Immunization Ctr
- 61. Comprehensive Inpatient Rehabilitation Facility
- 62. Comprehensive Outpatient Rehab Facility
- 65. End Stage Renal Disease Trmt Facility
- 71. State or Local Public Health Clinic
- 72. Rural Hlth Clinic
- 81. Independent Laboratory
- 99. Other Unlisted Facility

Directory:

FIELD SERVICE OFFICES

Aberdeen: 415 West Wishkah, Suite 1B

Aberdeen WA 98520-0013

(360) 533-8200

Bellevue: 616 120th Avenue NE, Suite C201

Bellevue WA 98005-3037

(425) 990-1400

Bellingham: 1720 Ellis Street, Suite 200

Bellingham WA 98225-4600

(360) 647-7300

Bremerton: 500 Pacific Avenue, Suite 400

Bremerton WA 98337-1904

(360) 415-4000

Colville: 298 South Main, Suite 203

Colville WA 99114-2416

(509) 684-7417 1-800-509-9174

East Wenatchee: 519 Grant Road

East Wenatchee WA 98802-5459

(509) 886-6500 1-800-292-5920

Everett: 729 100th St SE

Everett WA 98208-3727

(425) 290-1300

Kennewick: 500 N Morain, Suite 1110

Kennewick WA 99336-2683

(509) 735-0100 1-800-547-9411

Longview: 900 Ocean Beach Hwy

Longview WA 98632-4013

(360) 575-6900

Moses Lake: 3001 W Broadway Ave

Moses Lake WA 98837-2907

(509) 764-6900

Mount Vernon: 525 E College Way, Suite H

Mount Vernon WA 98273-5500

(360) 416-3000

Okanogan: 1234 2nd Avenue S

Okanogan WA 98840-0632

(509) 826-7345

Port Angeles: 1605 East Front Street, Suite C

Port Angeles WA 98362-4628

(360) 417-2700

Pullman: 1250 Bishop Blvd SE, Suite G

PO Box 847

Pullman WA 99163-0847

(509) 334-5296 1-800-509-0025

Seattle: 300 W Harrison Street

Seattle WA 98119-4081

(206) 281-5400

Spokane: 901 N Monroe Street, Suite 100

Spokane WA 99201-2149

(509) 324-2600 1-800-509-8847

Tacoma: 950 Broadway Suite 200

Tacoma WA 98402-4453

(253) 596-3800

Tukwila: 12806 Gateway Drive

PO Box 69050

Seattle WA 98168-1050

(206) 248-8240

Tumwater: PO Box 44851

7273 Linderson Way SW Olympia WA 98504-4851

(360) 902-5799

Vancouver: 312 SE Stonemill Dr, Suite 120

Vancouver WA 98684-3508

(360) 896-2300

Walla Walla: 1815 Portland Avenue, Suite 2

Walla WA 99362-2246

(509) 527-4437

Yakima: 15 W Yakima Avenue, Suite 100

Yakima WA 98902-3480

(509) 454-3700 1-800-354-5423

* indicates Regional Office (Revised 4/11/2001)

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